PREVIOUS PATIENT INSURANCE INFORMATION

Patient's or Authorized Person's Signature

IT IS YOUR RESPONSIBILTY to read and understand your insurance policy. The insurance company may not cover certain services and procedures, and you may have an annual out-of-pocket deductible that must be paid by you for vision services. It is also your responsibility to provide the correct insurance information. If you fail to do this, you will be responsible for the payment of services provided by Experts on Sight. In addition, any fees rejected by your insurance company will ultimately be your responsibility to pay.

I authorize payment of medical benefits to Experts on Sight for all medical services provided.

I authorize the release of any medical or other information necessary to process this claim.

I acknowledge my medical and/or vision insurance has not changed from my previous date of service at Experts on Sight.

Patient Name ____ **Date** ______________________
(Please Print)

Authorized Person's Signature ____

OFFICE USE ONLY

Contact Name ______________________________ Approval Code ________________________

Effective Date of Plan # _____________________ Co- Payment ________________________

Associate Initial ____________________________ Extra Payment (CL fitting, dilation, etc) ___________________

Ins. Payment Received _____________________ Patient Total _______________________

HCFA Printed __________________ Ins. Payment _______________________

Welcome back to our office! Please provide us with any changes to the following information.

LAST NAME ______________________________________ FIRST NAME ______________________________________

ADDRESS ____ CITY/STATE___________________________ZIP_________

HOME PHONE ____________________________________ WORK/CELL PHONE _______________________________

EMAIL____

HAVE YOU CHANGED YOUR VISION INSURANCE? Yes No *If yes, please complete a new Insurance Form.*

Medical History

This information is kept strictly confidential

Please list any Medical Conditions for which you are currently being treated for:

____

____

____

Currently Pregnant or Nursing ❒

Tobacco Use Former ❒

Tobacco Use Current ❒

Please list any Medications you are currently taking (include over-the-counter, vitamins or supplements):

If you have a written list, the receptionist would be more than happy to make a copy.

____

____

____

Please list any allergies you have (include medications, foods, animals, etc):

____

____

Pupil Dilation Information

Our office is committed to your eye health as well as ensuring you the best possible vision. We recommend pupil dilation in addition to the routine eye examination.

What are the side effects?

Blurred near vision and light sensitivity for up to 6 hours. Driving is not usually impaired, but may require extra caution.

_____ Yes, I would like pupil dilation in order to ensure the health of my eyes.

_____ No, I understand the importance of pupil dilation, but elect not to be dilated at this time.

Signature ____ Date ___________________

(If you are under the age of 18, your parent's signature is required)

We are a HIPAA Compliant Office.

Thank You

Risk Assessment For Macular Damage (AMD)

How many hours a day do you spend on your computer,
phone or tablet device? _______

How many servings of colorful fruits & veggies
do you eat each day? _______

What vitamins/supplements are you currently
taking any for eye health?_____________________________________

____

Please Circle Y or N for Screening Questions

Do you have a family history of **Macular Degeneration**?	Y	N
Do you smoke?	Y	N
If no, have you ever smoked or been exposed to second hand smoke?	Y	N
Do you have light colored eyes and/or complexion/hair?	Y	N
Has your primary care doctor told you to lower your weight?	Y	N
Do you take medication for cardiovascular disease or diabetes?	Y	N
Have you had cataract surgery?	Y	N
Do you spend more than an hour outside each day?	Y	N
Do you have problems with glare when driving at night or when using your computer?	Y	N

If you answered yes to 2 or more of the screening questions you may be at risk.

Last Name: ______________________ First Name: ____________________

Experts On Sight LLC. TM. September 20, 2015.

RETINAL IMAGING

We at Experts On Sight are proud to offer highly advanced Scanning Laser Retinal Imaging, which allows us to take images, safely, quickly and easily. A Scanning Laser Retinal Exam produces an image that is as unique as your fingerprint and provides us with a high resolution look at the health of your retina.

Many eye problems can develop without you knowing. You may not even notice any change in your sight. But, diseases such as macular degeneration, glaucoma, other health problems such as diabetes and high blood pressure can be seen with a thorough exam of the retina.

Retinal Exam provides:

- A scan to show a healthy eye or detect disease.
- A more detailed view of the retina, giving your doctor an image that can't be obtained by any other means.
- The opportunity for you to view and discuss the Retinal Image of your eye with your doctor at the time of your exam.
- A permanent record for your file, which allows us to view your images each year to look for changes.

We strongly recommend that all of our patients receive this evaluation. It is especially important for those patients who spend significant time looking at digital screens such as COMPUTER MONITORS, HDTV's, LAPTOPS, TABLETS, CELL PHONES etc, have a history of high blood pressure, diabetes, retinal problems or have a family member which suffers from retinal problems.

This state of the art procedure requires an addition 3 to 5 minutes of your time and there is an additional fee of only $39.00. **HOWEVER, CHILDREN UNDER THE AGE OF 18 WILL ALWAYS BE SCANNED AT NO CHARGE****

Please check YES or NO below and sign.

_____ YES, I would like an examination including the Scanning Laser Retinal Imaging.

_____ NO, I understand the importance of Digital Retinal Imaging and understand this test would be in my best interest, but, at his time, I prefer the General Eye Examination only which will not include the Digital Retinal Imaging.

Signature: ____ Date _______________

**Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out "certain eye diseases. In the latter case, you may be able to submit your bill for the retinal image or we will bill it on your behalf.

VISUAL FIELD SCREENING

Visual Field Analysis is a highly sophisticated, computerized system for assessing the neurological function of your vision. Unfortunately, routine eye examinations do not detect many diseases in their early stages. However, the Visual Field Analyzer is like having a "cat scan" specifically for the eye.

The Visual Field Analyzer can detect diseases such as pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to vascular problems and medications.

We strongly recommend that all of our patients over the age of 30 receive this evaluation. It is especially important for those patients who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems or have a family member which suffers from glaucoma or retinal problems.

This state of the art procedure requires an addition 10 to 15 minutes of your time and there is a nominal fee of $25.00.

Please check the appropriate box below and sign.

_____ I would like a Comprehensive examination including the Visual Field Screening.

_____ I understand the importance of the Visual Field Screening and understand this test would be in my best interest, but, at his time, I prefer the General Eye Examination only which will not include the Visual Field Screening.

Signature: ____ Date _______________

Please note that while this test is "optional" for some individuals, it represents preventative health care for others. It may be required to "rule-out"certain eye diseases. In the latter case, you may be able to submit your bill for the visual field screening to your major medical insurance company for reimbursement. Other more comprehensive procedures may be found to be necessary and billed at a higher rate.

Experts on Sight, LLC
3303 S Lindsay Rd, Ste 101
Gilbert, AZ 85297
480-292-9835 phone 480-292-9836 fax

CONTACT LENS EVALUATION INFORMATION

Contact lenses are medical devices controlled by the FDA and there is an expected "standard of care" required for contact lens wearers. We are dedicated to providing quality care to ensure your optimal comfort, vision, and most importantly, eye health.

It is not possible to determine in advance whether or not you will be a successful contact lens wearer, due to many factors that can influence your success. These factors include, but are not limited to: your expectations; unusual prescription; corneal shape; eyelid anatomy; manual dexterity; allergies; tear quantity; use of certain medications; willingness to return for follow-up care; improper lens care; and inability to follow lens care instructions or wearing schedule. Please discuss any factors you think may be a potential problem with the doctor before the lens fitting process.

There is a contact lens evaluation fee (starting at $90) which covers the initial evaluation to determine the most appropriate lenses and any additional contact lens related visits for up to 60 days. Additional fees will be charged in cases where extra follow-up visits or additional diagnostic lenses are required. In the event of any irritations or infections during the course of the fitting, the doctors will manage your eye(s) as a medical condition. The remainder of the contact lens evaluation will resume after the medical issue is resolved. We will provide a full lens care kit and instructions on caring for and wearing the lenses, including teaching insertion and removal of lenses.

A routine comprehensive eye exam is required in order to complete any contact lens fitting and evaluation. If it has been more than 3 months since your last routine eye exam, you will be required to have a complete comprehensive eye exam as well as a contact lens evaluation in order to be prescribed contact lenses.

Boxes of contacts can only be returned for an exchange if they are **unopened, unmarked**, **do not expire within 2 years, and in original condition, within 3 months. <u>Professional fees and lens care products are non-refundable</u>**.

We appreciate your selection of our office to provide your contact lens services. We will do everything possible to affirm your continued trust in our care. If you have any additional concerns or questions, please do not hesitate to ask our doctors' or courteous team members.

____________________________________ __________________
Patient's Name Date

____
Patient Initial/Parent Initial if minor